COMMONWEALTH OF MASSACHUSETTS

Middlesex, SS.

Board of Registration in Medicine
Adjudicatory Case No. 2013-038

In the Matter of

TZVETAN TZVETANOV, M.D.

**CONSENT ORDER**

Pursuant to G.L. c. 30A, § 10, Tzvetan Tzvetanov, M.D. (Respondent) and the Board of Registration in Medicine (Board) (hereinafter referred to jointly as the "Parties") agree that the Board may issue this Consent Order to resolve the above-captioned adjudicatory proceeding. The Parties further agree that this Consent Order will have all the force and effect of a Final Decision within the meaning of 801 CMR 1.01(11)(d). The Respondent admits to the findings of fact specified below and agrees that the Board may make the conclusions of law and impose the sanction set forth below in resolution of investigative Docket Nos. 11-458 and 12-154.

Findings of Fact

1. The Respondent was born on June 13, 1964. In 1988, he graduated from the Charles University Faculty of Medicine in Prague, Czech Republic. He has been licensed to practice medicine in Massachusetts since 2000, under certificate 204641. He is board-certified in Internal Medicine.

2. The Respondent owns a solo practice in North Andover, Massachusetts. He is affiliated with Lawrence General Hospital, Holy Family Hospital and Medical Center, and Anna Jacques Hospital.

Patient A

3. The Respondent was Patient A's primary care physician as of February 2002, when Patient A was thirty-one years old, until January 24, 2011, when the Respondent discharged Patient A from his practice.

4. As of February 2002, the Respondent was prescribing methadone to Patient A for chronic pain management, following a cervical neck fusion in 2000.

5. The Respondent continued to prescribe methadone to Patient A during most of the course of his treatment.

6. In July 2003 and in June 2009, the Respondent diagnosed Patient A as suffering from depression. He did not document the basis for the diagnosis or what the treatment would be.

7. At various times in 2005, 2006 and 2008, the Respondent issued prescriptions for mirtazepine to Patient A, without documenting why this was prescribed.

8. At various times, the Respondent issued prescriptions for trileptal and clonidine, without documenting why this was prescribed.

9. The Respondent did not document Patient A's response to mirtazepine, trileptal or clonidine, all of which have the potential to cause morbidity.

10. In January 2010, the Respondent noted that Patient A had chronic pain syndrome and was functioning very well. Patient A was compliant and was not abusing his medication at that visit

11. In April 2010, the Respondent advised Patient A that, unless Patient A tapered off methadone, the Respondent would no longer provide him with medical care.

12. In June 2010, the Respondent noted that Patient A had been successfully weaned off methadone.

13. The Respondent continued to prescribe methadone to Patient A throughout 2010.

14. From April 2010 to January 20, 2011, the monthly distribution of 10 mg methadone prescribed by the Respondent to Patient A went from 450 pills to 165 pills.

15. In December 2010, Patient A complained of severe neck pain with diminished range of motion.

16. When the Respondent examined Patient A on December 21, 2010, he noted, "Severe muscle spasm in the neck that the patient cannot turn the head to left or right, even slight movement of the upper extremities reproduces the neck pain. He does have severe muscle spasm and contracture."

17. The Respondent diagnosed a neck contusion but did not reference the mechanism of the contusion.

18. The Respondent's records do not show that he performed a neurologic examination, or that he considered the possibility of spinal cord injury or nerve root injury.

19. The Respondent sent Patient A to a pain clinic and ordered an MRI of Patient A's spine.

20. The Respondent noted that the MRI yielded no evidence suggesting further treatment with methadone.

21. The Respondent continued to treat Patient A with methadone.

22. In fact, the MRI report revealed moderate to severe neuroforaminal stenosis at the C3-4 and C4-5 levels.

23. On January 19, 2011, the Respondent met with Patient A. The Respondent noted that, "The patient is still in significant pain"

24. The Respondent noted that Patient A would continue with the pain clinic and would see a spinal surgeon.

25. The Respondent prescribed methadone, 10 mg #165, to Patient A on or about January 19, 2011, confirming that Patient A will continue with the Pain Clinic and see the spinal surgeon.

26. The Respondent did not document why he prescribed methadone to Patient A.

27. On January 24, 2011, the Respondent wrote to Patient A stating that he would no longer be providing further medical care to him.

28. The Respondent said that he discharged Patient A from his practice because Patient A repeatedly violated his pain agreement.

29. The Respondent's records do not reflect that Patient A violated his pain agreement.

30. The Respondent's records do not contain any documented actions by Patient A that warranted his discharge from the Respondent's practice.

31. The Respondent's treatment of Patient A fell below the standard of appropriate medical care in that:

a) The Respondent failed to adequately document the basis for the diagnosis and treatment of Patient A's depression and pain;

b) The Respondent failed to document the reason he prescribed mirtazepine, trileptal and clonidine;

c) The Respondent did not assess Patient A's response from the use of mirtazepine, trileptal and clonidine; and

d) The Respondent acted unprofessionally in prescribing methadone to Patient A in January 2011, and discharging Patient A from his practice shortly thereafter.

Patient B

32. The Respondent became Patient B's primary care physician on February 14, 2011, when Patient B was sixty-two years old.

33. At the February 14, 2011 visit, the Respondent noted that Patient B's history included tobacco abuse and hyperlipidemia, which are risk factors for peripheral vascular problems.

34. The Respondent's documented examination failed to comment on Patient B's peripheral vascular status.

35. On February 14, 2011, Patient B's history was negative for diabetes.

36. On March 15, 2011, Patient B saw the Respondent for a fungal rash. The Respondent also documented an elevated glucose of 113, and triglycerides of 401.

37. Elevated glucose, elevated triglycerides and fungal rash are consistent with pre-diabetes, and should have led the Respondent to obtain a hemoglobin A1c or glucose tolerance test.

38. The Respondent next saw Patient B on August 2, 2011. The Respondent drew blood on that day.

39. Blood results obtained on August 5, 2011, show an A1c of 8.0, which is diagnostic for diabetes.

40. The Respondent's records do not show that the Respondent notified Patient B about the A1c results.

41. The Respondent prescribed metformin 500 mg tablets to Patient B on August 19, 2011.

42. While the Respondent's record does indicate that he counseled Patient B at most visits that he should follow a low-fat, low-cholesterol diet, exercise, lose weight, and quit

smoking, there is no record that the Respondent counseled Patient B about his diabetes at any time in 2011.

43. On December 8, 2011, Patient B visited the Respondent's office for lab work. Blood results showed a glucose level of 168.

44. Although there is some indication that Respondent saw Patient B on December 12, 2011, there are no office notes concerning this visit.

45. Although the Respondent recalled seeing Patient B on February 3, 2012, there are no office notes concerning this visit.

46. The Respondent did not discuss Patient B's diabetes during the February 3, 2012 office visit.

47. Patient B submitted a urine sample for testing on February 3, 2012. The urine result showed 3+ for glucose, which is indicative of diabetes.

48. The Respondent failed to communicate the urine lab results to Patient B, despite multiple requests to do so in February 2012.

49. On March 2, 2012, Patient B's son called the Respondent's office and reported that, on March 1, 2012, Patient B had gone to the emergency department of a local hospital. Patient B's blood sugar was 513.

50. The Respondent's son questioned how the Respondent could have taken blood and urine samples without discovering that Patient B was diabetic.

51. The Respondent told Patient B's son that he would not discuss Patient B's treatment without permission from Patient B.

52. On February 14, 2011, Patient B had given the Respondent written permission to communicate with Patient B's son about Patient B's medical condition.

53. On March 8, 2012, Patient B visited the Respondent. Patient B had a non-fasting blood sugar of 438.

54. The Respondent's office notes dated March 8, 2012, noted that the Respondent had last seen Patient B in August 2011.

55. The Respondent noted that Patient B "is just diagnosed with type-II full-blown diabetes which progressed quite quickly in the last six months."

56. The Respondent told Patient B that he had full-blown diabetes and needed to be treated aggressively.

57. The Respondent noted that Patient B was taking glyburide 5 mg daily.

58. Glyburide is a medication used to treat Type 2 diabetes.

59. There were no notes showing when glyburide therapy began.

60. The Respondent started Patient B on glucovanse at the March 8, 2012 visit.

61. The Respondent did not note that he had provided any information to Patient B concerning how to monitor his glucose levels, or what signs to watch for.

62. The Respondent did not perform a urine screen for microalbuminuria, an important prognostic marker for renal disease.

63. The Respondent did not refer Patient B to an ophthalmologist to determine whether there were any microvascular complications.

64. Patient B transferred to a new primary care physician after the March 8, 2012 visit with the Respondent.

65. The Respondent's treatment of Patient B fell below the standard of appropriate medical care in that:

a. The Respondent failed to recognize or follow-up on the March 2011 abnormal laboratory results, which were indicators of pre-diabetes;

b. The Respondent inadequately followed-up on Patient B's August 2011 A1c of 8.0, in that there is no record that the Respondent communicated the results to Patient B, communicated any urgency in regards to scheduling an office visit, made any follow-up notes, or advised Patient B about treatment;

c. The Respondent failed to adequately treat Patient B as a result of the March 2012 office visit, in that the Respondent provided no instructions to Patient B concerning glucose monitoring, and did not make appropriate referrals to specialists;

d. The Respondent repeatedly failed to adequately document his treatment of Patient B; and,

e. The Respondent failed to adequately communicate with Patient B and Patient B's son, who was authorized to receive Patient B's medical information.

66. In June 2012, the Respondent implemented a new electronic medical record system that uses Athena-based medical assessment software.

67. The software generates prescriptions that are sent electronically to the patient's pharmacy, and the prescriptions are documented in the patient's medical record.

68. The Respondent now has a medical software system which receives and routes clinical information for easier use and access.

Conclusions of Law

A. The Respondent has violated G.L. c. 112, § 5, ninth par. (c) and 243 CMR 1.03(5)(a)3, in that he placed into question his competence to practice medicine by practicing with negligence on repeated occasions.

B. The Respondent has engaged in conduct that undermines the public confidence in the integrity of the medical profession. *See Levy v. Board of Registration in Medicine*, 378 Mass. 519 (1979); *Raymond v. Board of Registration in Medicine*, 387 Mass. 708 (1982).

Sanction and Order

The Respondent is hereby admonished. The Respondent is required to perform the following: The Respondent must complete ten (10) hours of continuing professional development ("CPD") courses that focus on patient management and record keeping. Furthermore, the CPDs must be completed within one (1) year of the date on which the Board approves the Consent Order.

Execution of this Consent Order

The Respondent shall provide a complete copy of this Consent Order, with all exhibits and attachments within ten (10) days by certified mail, return receipt requested, or by hand delivery to the following designated entities: any in- or out-of-state hospital, nursing home, clinic, other licensed facility, or municipal, state, or federal facility at which the Respondent practices medicine; any in- or out-of-state health maintenance organization with whom the Respondent has privileges or any other kind of association; any state agency, in- or out-of-state, with which the Respondent has a provider contract; any in- or out-of-state medical employer, whether or not the Respondent practices medicine there; the state licensing boards of all states in which the Respondent has any kind of license to practice medicine; the Drug Enforcement Administration Boston Diversion Group; and the Massachusetts Department of Public Health Drug Control Program. The Respondent shall also provide this notification to any such designated entities with which he becomes associated in the year following the date of imposition of this admonishment. The Respondent is further directed to certify to the Board within ten (10) days that he has complied with this directive.

The Board expressly reserves the authority to independently notify, at any time, any of the entities designated above, or any other affected entity, of any action it has taken.

Tzvetan Tzvetanov, M.D.
Licensee

6/19/13
Date

Paul R. Keane
Attorney for the Licensee

6/20/13
Date

Pamela J. Meister
Complaint Counsel

6/21/13
Date

So ORDERED by the Board of Registration in Medicine this 14th day of August, 2013.

Candace Lapidus Sloane, MD

Candace Lapidus Sloane, M.D.
Chair



SENT CERTIFIED MAIL 8/15/13 (mg)